Dover Pediatrics, PLLC
www.doverpediatrics.org

Annual Registration; Insurance; HIPAA & Consent Form

Today's Date: _____

_____ _____ _____
Patient's First Name **Last Name** **Date of Birth**

Your Pharmacy:_____City:_____State_____

Race: □ White-Caucasian □ American Indian/Alaskan □ Asian □ Black/African American □ Hawaiian □ Hispanic/Latino/Spanish Origin □ Other

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Prefer not to answer ***Patient's Sex:*** □ Female □ Male □ Other _____ □ Not sure

*** Language(s) Spoken at home:** □ English □ Other: _____ **Do you need an language Interpreter?** □ Yes □ No

THE FOLLOWING INFORMATION WILL BE ENTERED INTO YOUR CHILD'S ELECTRONIC HEALTH FORM: **Email Address:** _____@_____

Contact Preference(s): □ Home Phone: _____ □ Cell Phone: _____ □ Text: _____

Child's current medications:		

Please review the following medical conditions and list those applicable to your child or your child's family members:

Medical Condition	Patient Yes	Patient No	Mother's Family Yes	Mother's Family No	Father's Family Yes	Father's Family No
Seizures	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□
Allergies: *Seasonal*	□	□	□	□	□	□
Food	□	□	□	□	□	□
Drug	□	□	□	□	□	□
Asthma	□	□	□	□	□	□
Blood Disorders: *Anemia*	□	□	□	□	□	□
Bleeding Problems	□	□	□	□	□	□
Chronic Infections: *Hep B*	□	□	□	□	□	□
Hep C	□	□	□	□	□	□
HIV	□	□	□	□	□	□
Cancer	□	□	□	□	□	□
Depression/Anxiety	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□
Hearing Problems	□	□	□	□	□	□
High Cholesterol	□	□	□	□	□	□
Arthritis	□	□	□	□	□	□
Learning Problems	□	□	□	□	□	□
Congenital Malformations	□	□	□	□	□	□
Substance Abuse	□	□	□	□	□	□
Other- please explain:	□	□	□	□	□	□
Has your child ever seen a dentist?	□	□	If yes, *date* of child's last dental visit:		_____	
Has your child ever had surgery?	□	□	*Please list:*			
Has anyone in your family worried about affording groceries in the past twelve (12) months?	□	□				
Are there any smokers in your child's home?	□	□	*If yes, how many?*		□ *Inside Smokers* □ *Outside Smokers only*	

Mother's Name: _____DOB: _____ Occupation: _____

Father's Name: _____DOB: _____ Occupation: _____

Sibling's Name: _____DOB: _____ Occupation: _____

Sibling's Name: _____DOB: _____ Occupation: _____

Sibling's Name: _____DOB: _____ Occupation: _____

Does your child live with you Monday through Sunday? □ Yes □ No - *If parents aren't together, what is the custody and visitation arrangement?*

_____

List all people living with your child in their home(s):_____

_____

*** Dover Pediatrics, PLLC complies with applicable Federal civil rights laws and does not exclude or discriminate people nor treat them differently on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation or health status from our practice. If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or at our offices.**

INSURANCE INFORMATION

Primary Insurance Company Name	Policy Number	Group/Plan Number
Cardholders Name	**Date of Birth**	**Effective Date of Coverage**
Secondary Insurance Company Name	**Policy Number**	**Group/Plan Number**
Cardholders Name	**Date of Birth**	**Effective Date of Coverage**

- ***By completing the information above, I certify that I or my dependent above have insurance coverage as indicated above and assign directly to Dover Pediatrics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions as well as to release information necessary for the payment of claims.***

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about your child. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by asking for an updated copy or contacting the HIPAA compliance officer.

You have the right to request that we restrict how protected health information about your child is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing the patient registration form, you consent to our use and disclosure of protected health information about your child for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Once we have received your consent, all subsequent treating or consulting physicians, other health care professionals, laboratories, health care facilities, and health insurance companies, may receive copies of medical records without specific authorization, with the exception of records of genetic testing, mental health, alcoholism, drug abuse and HIV/AIDS treatment.

□ *I request a complete copy of Dover Pediatrics, PLLC's Summary Notice of Health Information Practices (HIPAA)*

_____ _____

Parent/Guardian Signature **Date**

PRIVACY NOTICE

I authorize Dover Pediatrics to *SHARE PERTINENT MEDICAL INFORMATION* only as necessary with other healthcare providers to provide coordination of, or a continuation of medical care. I understand this may include sensitive information such as, but not limited to: Mental Health, HIV/STD evaluations and/or treatment, pregnancy and alcohol or substance abuse.

I authorize Dover Pediatrics to *RECEIVE PERTINENT MEDICAL INFORMATION* from any provider they have referred my child to. I may restrict, in writing, the release of any confidential information, previously authorized except as required by law and to the extent that action has already been taken on my behalf and that does not compromise accepted standards of medical care. I understand and accept the potential risk/consequence of sending insurance or medical information by FAX.

- **Please check off applicable boxes:**

YOU HAVE MY PERMISSION TO CONFIRM MY APPOINTMENTS BY:

□ LEAVING A MESSAGE AT HOME OR ANSWERING MACHINE

□ LEAVING A TEXT MESSAGE ON MY CELL PHONE

□ LEAVING A VOICEMAIL MESSAGE ON CELL PHONE

□ LEAVING A MESSAGE AT MY WORK NUMBER IF LISTED - OR *WITH*:

Name: _____

Relationship: _____ **Phone:** _____

- **We may discuss your child's medical information/condition with:** ***(List each Name/Relationship)***

_____

_____